



**CITY OF MARLBOROUGH  
NOTICE OF EMPLOYEE ACCIDENT**

*This form must be submitted to the Human Resources Dept. within 24 hours after an accident which results in an injury.*

Dept. No: _____
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**CLAIMANT'S FORM (PAGE ONE)**

**PLEASE PRINT OR TYPE  
INCOMPLETE FORMS WILL BE RETURNED**

DEPARTMENT: \_\_\_\_\_ DATE OF THIS REPORT: \_\_\_\_\_

**Injured  
Person**

Name of injured: \_\_\_\_\_ SS#: \_\_\_\_\_  
(First Name) (Initial) (Last Name)

Address: No and St.: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_

Check (X) Married: \_\_\_ Single: \_\_\_ Widowed: \_\_\_ Widower: \_\_\_ Divorced \_\_\_ Male: \_\_\_ Female: \_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

(a) Occupation when injured \_\_\_\_\_ (b) Was this his or her regular occupation: \_\_\_\_\_  
(If not, state in what department or branch of work regularly employed): \_\_\_\_\_

(a) How long employed \_\_\_\_\_

(b) No. hours worked per day \_\_\_\_\_ Wages per day \$ \_\_\_\_\_

(c) No. days worked per week: \_\_\_\_\_ Average weekly earnings \$ \_\_\_\_\_

**Time  
And  
Place**

Place where injury occurred \_\_\_\_\_ State if injury occurred on or off employer's premises \_\_\_\_\_

Date of injury \_\_\_\_\_ 20 \_\_\_\_\_. Day of week: \_\_\_\_\_ Hour of day \_\_\_\_\_ AM \_\_\_\_\_ PM

Date disability began \_\_\_\_\_ 20 \_\_\_\_\_. A.M. \_\_\_\_\_ P.M.

Was injured paid in full for this day? \_\_\_\_\_

To whom and when was injury reported: \_\_\_\_\_

Title: \_\_\_\_\_

**Cause  
Of  
Injury**

Machine, tool or thing causing injury: \_\_\_\_\_

Kind of power (hand, tool, electrical, steam, etc.) \_\_\_\_\_

Part of machine on which accident occurred: \_\_\_\_\_

(a) Was safety appliance or regulation provided \_\_\_\_\_ (b) was it in use at time: \_\_\_\_\_

Was accident caused by injured's failure to use or observe safety appliance or regulation: \_\_\_\_\_

Describe fully how accident occurred and state what employee was doing when injured: \_\_\_\_\_

Names and addresses of witnesses: \_\_\_\_\_

**Nature  
Of  
Injury**

Nature of Injury and Body Part Affected: \_\_\_\_\_

Did you seek medical treatment? \_\_\_\_\_ If so, please provide the name and address of physician or hospital \_\_\_\_\_

Probable length of disability: \_\_\_\_\_ Has injured returned to work: \_\_\_\_\_

If so, date and hour: \_\_\_\_\_ At what occupation: \_\_\_\_\_

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

(Injured Person must complete and sign this section) NAME: \_\_\_\_\_ Today's Date: \_\_\_\_\_

CHECK HERE IF THIS IS A MOTOR VEHICLE ACCIDENT. POLICE REPORT MUST BE ATTACHED.

**CITY OF MARLBOROUGH  
NOTICE OF EMPLOYEE ACCIDENT**

**CLAIMANT'S FORM (PAGE TWO)**

**FUTURECOMP CONSENT FOR RELEASE OF MEDICAL INFORMATION**

**PLEASE PRINT OR TYPE:**

Name of Injured Employee: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I authorize the release of medical information and facts regarding this injury, including reports and records, results, or diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment relating to this injury. This information is to be used for purpose of evaluating and handling my claim for injury as a result of an accident on or about the date of injury as identified above on this form.

This will also authorize FutureComp Medical Case Manager if assigned to me to have access to all medical records and Utilization Review Records. The Case Manager may discuss pertinent information with professionals involved in my case to share information as appropriate and necessary for coordination of health care services and coordination with employer for return to work. I understand authorization for Case management purposes is voluntary and not required.

I am willing that a photocopy of this authorization be accepted with the same authority as the original.

\_\_\_\_\_  
Signature of Injured Employee

\_\_\_\_\_  
Date

**ACCIDENT INVESTIGATION REPORT  
SUPERVISOR'S FORM**

**PLEASE PRINT OR TYPE**

ALL ACCIDENTS MUST BE INVESTIGATED AND THIS FORM MUST BE COMPLETED IN FULL BY **THE SUPERVISOR AND/OR DEPARTMENT HEAD**. INCOMPLETE FORMS WILL BE RETURNED. WHEN COMPLETED, PLEASE SEND TO: **HUMAN RESOURCES DEPT., CITY HALL, 140 MAIN STREET** WITHIN 24 HOURS AFTER AN ACCIDENT.

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**PART I – GENERAL INFORMATION**

DATE OF THIS REPORT: \_\_\_\_\_

NAME OF EMPLOYEE: \_\_\_\_\_ DEPT: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME \_\_\_\_\_ AM / PM

EXACT LOCATION: \_\_\_\_\_

JOB ACTIVITY AT TIME OF ACCIDENT: \_\_\_\_\_

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**PART II – DESCRIPTION OF ACCIDENT (WHAT HAPPENED?)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PART III – THE CAUSE OF THE ACCIDENT**

A. DESCRIBE UNSAFE ACTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. DESCRIBE UNSAFE CONDITIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PART IV – CORRECTIVE ACTIONS (WHAT ACTION HAS BEEN TAKEN OR WILL BE TAKEN TO CORRECT THE UNSAFE ACT AND/OR UNSAFE CONDITION)**

\_\_\_\_\_  
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\_\_\_\_\_

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**PART V – REMARKS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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REVIEWED BY  
DEPARTMENT HEAD: \_\_\_\_\_

SIGNED: \_\_\_\_\_  
SUPERVISOR:

FIRE & POLICE DEPARTMENTS: \_\_\_\_\_ ORIGINAL TO HUMAN RESOURCES DEPT. \_\_\_\_\_ COPY TO LEGAL DEPARTMENT

NOTE: THIS FORM DOES NOT TAKE THE PLACE OF THE REGULAR ACCIDENT REPORT REQUIRED BY THE INDUSTRIAL ACCIDENT BOARD. (USE OTHER SIDE IF ADDITIONAL SPACE IS REQUIRED.)

## ELEMENTS OF ACCIDENT INVESTIGATION

### **PURPOSE:**

The specific purpose of Accident Investigation is to determine the basic causes not to fix blame. The majority of accidents which result in personal injury or property damage are the direct result of an unsafe act, an unsafe condition or a combination of both. Analyze the causes and develop corrective measures.

### **SIX QUESTIONS TO ANSWER AS THE BASIS OF AN ACCIDENT INVESTIGATION:**

1. **WHO** was injured?
2. **WHEN** did it happen?
3. **WHERE** did the accident happen?
4. **HOW** did the accident happen?
5. **WHAT** were the materials, machines, equipment or conditions involved?
6. **WHY** did it happen?

### **PRINCIPLES WHICH SHOULD BE OBSERVED:**

**USE COMMON SENSE** – Stick to the facts, weigh their value, reach justified conclusions.

**INVESTIGATE EACH CLUE** – An apparently reasonable conclusion will often be changed by exploring factor which may not appear to be important.

**CHECK FOR UNSAFE CONDITIONS AND UNSAFE ACTS** – Both are present in the great majority of accidents.

**MAKE RECOMMENDATIONS** – No investigation is complete unless corrective action is suggested.

**INVESTIGATE ALL ACCIDENTS** – This should be done whether or not personal injury or property damage occurs. It may provide a basis for prevention of future occurrences.

**PREPARE REPORT** – Written reports are helpful tools for study and analysis to determine specific areas or operations in which accidents occur.

**NOTE:** Never say a worker was “careless”. This is an effect, not a cause. If you think the worker was careless, find out why – there is always a reason.